U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 13Apr2001

CASE NO. 2000-BLA-449

In the Matter of:

EMMA M. CLEVENGER, Survivor of
VERNARD CLEVENGER,
Claimant

v.

GRAFTON COAL COMPANY,
Employer

and

WV CWP FUND
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

James Hook, Esq.
For the Claimant

Robert Weinberger, Esq.
For the Employer

Before: GERALD M. TIERNEY
Administrative Law Judge

DECISION AND ORDER - AWARDING BENEFITS

This matter arises from a survivor's claim for Black Lung Benefits filed on September 1, 1998 (DX 1).[1]

The Department of Labor found Claimant entitled to benefits (DX 44). Employer disagreed (DX 46). On February 9, 2000, the Department of Labor transferred this case to the Office of Administrative Law Judges to be set for hearing (DX 49).

I held a formal hearing on August 10, 2000 in Weston, West Virginia.

Background

The miner was born on June 10, 1925 and died on February 21, 1995 at the age of 69 (DX 5). He worked at least 20 years as a coal miner (TR 9). Grafton Coal Company was properly identified as the responsible operator (TR 8). The miner's wife, Claimant, is an eligible survivor with no dependents (DX 1, 4).

Applicable Regulations[2]

To receive Black Lung Benefits as a qualifying surviving spouse of a miner, the spouse must prove: (1) that the miner suffered from pneumoconiosis; (2) that the miner's pneumoconiosis arose, at least in part, out of coal mine employment; and (3) that the miner's death was due to pneumoconiosis. §§718.202, 718.203, 718.205(c)(1). If pneumoconiosis was not the principal cause of the miner's

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[1] The Black Lung Benefits Act, as amended, is codified at 30 USC §901 with its implementing regulations found at Title 20 of the Code of Federal Regulations. The following abbreviations are used in this decision: DX - Director's Exhibit; CX - Claimant's Exhibit; EX - Employer's Exhibit; TR - hearing transcript; BCR - board-certified radiologist; and B - B-reader.

[2] On February 13, 2001, I issued an Order to Submit Briefs, whereby I provided the parties with an opportunity to address the application of the newly amended regulatory provisions, in accordance with the terms of a Preliminary Injunction Order of the U.S. District Court for the District of Columbia, dated February 9, 2001. Pursuant to that Order, briefs were submitted on behalf of the Claimant, the Director, and the West Virginia Coal-Workers' Pneumoconiosis Fund. The Director's and Claimant's briefs state that application of the new regulations would not affect the outcome of the claim. Counsel for the West Virginia Coal-Workers Pneumoconiosis Fund submitted a brief which suggests that application of the new regulations would change the criteria for development of medical evidence as well as determination of entitlement to benefits and would therefore affect the outcome of this claim. After careful review, I find that, whether one applies the newly amended regulations or the pre-February 19, 2001 regulations, the outcome of the claim is identical.

death, a surviving spouse is entitled to benefits only if "the evidence establishes that pneumoconiosis was a substantially contributing cause of death." §718.205(c)(4). A showing that pneumoconiosis "hastened" the miner's death satisfies the substantial contribution requirement of §718.205(c)(4). *Shuff v. Cedar Coal Co.*, 967 F.2d 977 (4th Cir. 1992). The spouse has the burden of persuasion by a preponderance of the evidence to establish each of these elements. *U.S. Steel Mining Co., Inc. v. Director, OWCP*, 187 F.3d 384 (4th Cir. 1999).

Pneumoconiosis

Chest x-ray, autopsy, and physician opinion evidence are the means available to Claimant to establish the existence of pneumoconiosis. §718.202.

Below is a summary of the chest x-ray evidence.[3]

Exhibit	Date of X-ray	Physician/Radiological qualifications	Impression
DX 47	4/25/77	Harron/---	1/2
DX 47	4/25/77	Wheeler/---	0/-
DX 47	4/25/77	Morgan/B	Completely negative
DX 47	9/6/77	Lapp/B	0/0
DX 47	4/7/78	NIOSH	No pneumoconiosis
DX 47	12/16/79	Bristol/BCR,B	0/0
DX 47	12/16/79	Morgan/B	Completely negative
DX 47	12/26/79	Wilson/---	0/1
DX 47	1/19/80	Bellotte/---	0/1
DX 47	11/25/81	Renn/B	0/0
DX 32	6/21/93	Navani/BCR,B	Completely negative

[3] Chest x-rays not read specifically for the presence or absence of pneumoconiosis and classified as required by §718.102(b) or appearing on a Department of Labor or other ILO classification sheet are not listed here. *See* DX 8-10, 47.

DX 33	11/22/93	Navani/BCR,B	Completely negative
DX 35	12/8/93	Navani/BCR,B	Completely negative
CX 1,3	12/8/93	Brandon/BCR,B	1/1
DX 31	2/18/95	Navani/BCR,B	Completely negative
DX 30	2/18/95	Gaziano/B	Unreadable
CX 2	2/18/95	Brandon/BCR,B	1/1

I focus on the readings of the dually-qualified physicians, the physicians who are both board-certified in radiology and have achieved B-reader status. Dr. Brandon's readings of the miner's latest 1993 and 1995 chest x-rays identifying the existence of pneumoconiosis are challenged by the Dr. Navani. Also, the earlier reading of Dr. Bristol does not identify the existence of pneumoconiosis. Claimant does not meet her burden of proof. Claimant does not establish, by the preponderance of the chest x-ray evidence, the existence of pneumoconiosis at §718.202(a)(1).

Four pathologists addressed the autopsy evidence.

Dr. Franco performed the autopsy (DX 7). She diagnosed the presence of anthracotic pigmentation. This does not suffice as a diagnosis of pneumoconiosis. *See* §718.202(a)(2).

Dr. Franco referred the miner's slides to Dr. Koss (DX 9). Dr. Koss advised Dr. Franco that he concurred with her diagnosis. Dr. Koss did not identify the existence of pneumoconiosis.

Dr. Naeye reviewed the autopsy slides and report and the miner's death certificate (DX 37). He reported that the minimal findings required to make the diagnosis of simple coal workers' pneumoconiosis were absent.

Dr. Rizkalla reviewed the autopsy slides and report along with the death certificate and listed lifetime evidence (CX 7). He found that the autopsy evidence met the criteria for a diagnosis of simple pneumoconiosis.

Dr. Rizkalla testified as to his qualifications (CX 10). He acknowledged that Dr. Naeye is also an experienced board-certified pathologist. Drs. Rizkalla and Naeye disagreed as to the existence of pneumoconiosis. The reports of Drs. Franco and Koss support the position of Dr. Naeye. Claimant does not meet her burden of proof. Claimant does not establish, by the preponderance of the autopsy evidence, the existence of pneumoconiosis at §718.202(a)(2).

Still, Claimant can prove the existence of pneumoconiosis at §718.202(a)(4) by physician opinion evidence establishing that the miner suffered from a respiratory or pulmonary impairment arising out of coal mine employment or pneumoconiosis as defined at §718.201.

In 1977, Dr. Post diagnosed pneumoconiosis (DX 47). Dr. Post did not provide the basis for his diagnosis. The earlier 1977 chest x-ray was initially read as positive, 1/2, for pneumoconiosis. The validity of the earlier 1977 pulmonary function study was challenged by Dr. Lapp.

In 1980, Dr. Bellotte noted Dr. Post's diagnosis of pneumoconiosis (DX 47). Dr. Bellotte stated that he read the miner's chest x-ray as 0/1. Dr. Belotte diagnosed chronic obstructive pulmonary disease not related to the miner's coal dust exposure. Dr. Bellotte did not provide the basis for his diagnosis of chronic obstructive pulmonary disease. He interpreted the pulmonary function test associated with his exam as showing normal ventilatory function.

In 1981, Dr. Mills submitted a summary of the miner's 1972-1978 medical history (DX 47). He reported granulomatous calcification on the miner's 1975 chest x-ray and dyspnea in 1976.

In 1981, Dr. Petsonk, a board-certified pulmonary specialist, evaluated the miner (DX 47). He concluded that there was no evidence of coal workers' pneumoconiosis. He added in a supplemental report that there was no evidence of ventilatory impairment arising from coal mine employment. The chest x-ray associated with Dr. Petsonk's exam was read as negative for pneumoconiosis. Dr. Petsonk reported that the miner's spirometry was within normal limits but for a decrease to 49% of predicted in the mid expiratory flow rate. He noted that the miner's diffusing capacity was 105% of predicted. He added that the miner's resting blood gases were entirely within normal limits.

A 1985 pulmonary function study was interpreted as showing a mild ventilatory impairment and severe small airway disease without significant bronchoreversibility (DX 47). There were no interpretive comments accompanying the arterial blood gas study performed on the same day.

Dr. O'Keefe's 1984-1994 treatment notes documented the miner's respiratory complaints and the diagnoses of bronchitis and chronic obstructive pulmonary disease (DX 10; *see also* DX 42).

Hospital records from West Virginia University in 1993 described the miner as suffering from steroid dependent chronic obstructive pulmonary disease (DX 8).

Dr. Petsonk's signature appeared on the results of a 1994 pulmonary function study interpreted as showing severe obstructive lung disease without evidence of reversibility after bronchodilator therapy (CX 4). An arterial blood gas study, performed on the same day, was interpreted as within predicted limits.

Records of the miner's care at Louis Johnson VA Medical Center, dating from 1988 to the miner's 1995 terminal admission, also documented the miner's respiratory complaints and the diagnosis of chronic obstructive pulmonary disease (DX 9; *see also* DX 37, 39, 42).

Dr. Jani of the VA Medical Center listed severe chronic obstructive pulmonary disease of several years duration on the miner's death certificate (DX 5).

Dr. O'Keefe and Dr. Jackson of the VA Medical Center submitted letters in 1999 linking black lung and the miner's chronic obstructive pulmonary disease (DX 40).

Dr. Fino, a board-certified pulmonary specialist, submitted his opinion based on his review of listed evidence (DX 36). He concluded that the miner did not suffer from an occupationally acquired pulmonary condition. He attributed the miner's respiratory impairment to smoking.

Dr. O'Keefe testified that the miner's severe lung disease was due, in part, to coal mine dust exposure (CX 9).

Dr. Rizkalla testified that smoking was not the only factor inducing the miner's chronic obstructive pulmonary disease (CX 10).

Again, §718.202(a)(4) provides Claimant a means to establish the existence of pneumoconiosis aside from the chest x-ray or autopsy evidence. A causal link, even a partial one, between the miner's respiratory or pulmonary condition and his coal mine dust exposure suffices to establish a diagnosis of pneumoconiosis.

I place little weight on Drs. Bellotte's and Petsonk's early opinions ruling out a causal nexus between the miner's pulmonary condition and coal mine dust exposure. Dr. Bellotte did not explain the basis for his 1980 diagnosis of chronic obstructive pulmonary disease not related to coal mine employment. He reported that the pulmonary function study associated with his exam showed normal ventilatory function. Dr. Petsonk's 1981 supplemental report concluded that the miner had no ventilatory impairment arising from coal mine employment. I point out that the only abnormality Dr. Petsonk reported on the miner's 1981 pulmonary function testing was a decreased mid expiratory flow rate. The miner's significantly more recent 1994 pulmonary function study, which carried Dr. Petsonk's signature, was interpreted as showing severe obstructive lung disease.

The 1985 pulmonary function study was interpreted as showing a mild ventilatory impairment and severe small airway disease. The diagnosis of obstructive pulmonary disease was part of the miner's diagnosed conditions from the late 1980's until his 1995 death. Again, severe obstructive lung disease was documented by 1994 pulmonary function testing and listed on the miner's death certificate. I acknowledge that Dr. O'Keefe's treatment records, the VA Medical Center records, the West Virginia University Hospital records, the 1985 and 1994 pulmonary function study results, and the death certificate all were silent as to the cause of the miner's lung disease.

The 1999 letters from Dr. O'Keefe and Dr. Jackson of the VA Medical Center were the first to link black lung to the miner's chronic obstructive pulmonary disease. However, it is the testimony of

Dr. O'Keefe that I find persuasive in establishing that link. Dr. O'Keefe discussed his longtime care of the miner. He explained that he is a cardiologist but that through the years he treated the miner more for lung problems than worsening heart failure. He added that by and large the debility the miner suffered over the years was pulmonary. Dr. O'Keefe acknowledged that the miner's smoking history contributed to his lung disease but testified that coal mine dust exposure also played a role.[4]

Dr. Fino rejected a diagnosis of pneumoconiosis or coal mine dust exposure playing a role in the miner's lung disease. Dr. Fino did this citing the chest x-ray and autopsy evidence. I have already found the preponderance of chest x-ray and autopsy evidence did not establish the existence of pneumoconiosis. Dr. Fino went on to explain why the results of miner's spirometry testing was not consistent with a coal dust related condition. He added that the miner's TLC, I assume to mean total lung capacity, was not reduced which ruled out the presence of restrictive lung disease and significant pulmonary fibrosis. However, it is not clear what pulmonary function studies Dr. Fino relied on to rule out coal mine dust exposure as at least a partial cause of the miner's pulmonary abnormality. Dr. Fino listed the evidence he reviewed. It did not include any of the pre-1984 evidence but for Dr. Petsonk's two paragraph December 17, 1981 supplemental report. The 1984 to 1995 evidence he listed, and as contained in the record before me, did not contain any pulmonary function study results. The 1994 pulmonary function study results, interpreted as showing severe obstructive lung disease, were not submitted until June 2000, a year after Dr. Fino's report was issued. Dr. Fino's summary chart of the objective findings he reviewed did not contain any pulmonary function study findings. Nor did Dr. Fino consider treating physician Dr. O'Keefe's testimony that linked the miner's lung disease to his coal mine dust exposure.

I acknowledge Dr. Fino as a board-certified pulmonary specialist. However, his opinion was

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[4] Dr. Rizkalla testified that smoking was not the only factor inducing the miner's chronic obstructive pulmonary disease but did not specifically identify coal mine dust exposure as the other factor. Dr. Rizkalla testified generally that the miner's lung disease was secondary to his exposure to coal dust. However, it is not clear how much of his opinion was based on his finding that the autopsy evidence established pneumoconiosis.

Dr. Naeye is also a pathologist. He concluded that pneumoconiosis was absent. Dr. Naeye went on to state that because coal workers' pneumoconiosis was absent, it could not have caused abnormalities in lung function. I do not consider this statement a persuasive basis to rule out a diagnosis of pneumoconiosis at §718.202(a)(4). Dr. Naeye did not consider the extensive lifetime evidence. It is not clear that he considered the diagnosis of pneumoconiosis beyond the autopsy evidence.

Nor does the record establish that pathologists Drs. Franco and Koss considered a diagnosis of pneumoconiosis within its broader definition at §718.201. They reported evidence of emphysema and bronchitis on autopsy but did not address the etiology of these pulmonary conditions.

not based on a complete review of the evidence. His report did not identify the specific pulmonary function study he relied on to rule out coal mine dust exposure as a cause of the miner's lung disease. I find the opinion of Dr. O'Keefe more persuasive. He was the miner's longtime treating physician. His opinion linking the miner's lung disease to his coal mine dust exposure is supported by Dr. Jackson of the VA Medical Center. Claimant has met her burden of proof. Claimant has established, by the preponderance of the physician opinion evidence, the existence of pneumoconiosis at §718.202(a)(4).

I must weigh together all the evidence relevant to the existence of pneumoconiosis. *Island Creek Coal Co. v Compton*, 211 F.3d 203 (4th Cir. 2000). While the preponderance of the chest x-ray and autopsy evidence did not establish the existence of pneumoconiosis, the preponderance of the physician opinion established the existence of the disease. Weighing together the chest x-ray evidence, the autopsy evidence, and the physician opinion evidence, I find that Claimant has established the existence of pneumoconiosis. Chest x-ray and autopsy evidence are isolated types of evidence whereas physician opinion evidence takes into consideration a totality of factors. Those factors include the longtime treatment of the miner, evidence of impairment, and the miner's history of exposures relevant to identify the origin of any impairment. Placing greater weight on the physician opinion evidence, I find that Claimant has established, by the preponderance of the evidence overall, the existence of pneumoconiosis at §718.202.

Arising Out of Coal Mine Employment

Employer did not submit evidence sufficient to rebut the §718.203(b) presumption that the miner's pneumoconiosis arose out of coal mine employment.

Death Due to Pneumoconiosis

The miner's terminal hospital admission occurred at the VA Medical Center. Dr. Jani signed the records of that admission and the death certificate. Both the hospital records and death certificate indicated that chronic obstructive pulmonary disease played a role in the miner's death. Again, these records did not address the etiology of the miner's chronic obstructive pulmonary disease.

Neither the autopsy report of Dr. Franco nor the confirmation report of Dr. Koss addressed the issue of whether pneumoconiosis or coal mine dust induced disease played a role in the miner's death.

Drs. Naeye and Fino specifically concluded that pneumoconiosis played no role in the miner's death. However, neither physician found pneumoconiosis to exist which is contrary to what I have found the preponderance of the evidence to establish.

It was Dr. O'Keefe's opinion that coal workers' pneumoconiosis hastened the miner's death. I

find Dr. O'Keefe's opinion, as the miner's longtime treating physician, the most persuasive. *See* §718.202(a)(4) discussion, *supra*. The 1999 letter from Dr. Jackson of the VA Medical Center also supports that conclusion. [5]

Claimant has met her burden of proof. Claimant has established, by the preponderance of the evidence, that coal workers' pneumoconiosis hastened the miner's death. §718.205(c); *Shuff, supra*. She is entitled to benefits.

Attorney Fees

An application by Claimant's attorney for approval of a fee has not been received and, therefore, no award of attorney's fees for services is made. Thirty days is hereby allowed to Claimant's counsel for the submission of such an application and attention is directed to §725.365 and §725.366 of the regulations. A service sheet showing that service has been made upon all parties, including Claimant, must accompany the application. Parties have ten days following the receipt of any such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

Grafton Coal Company is ORDERED to pay Claimant all benefits to which she is entitled under the Act commencing February 1995, the month of the miner's death. §725.503(c).

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GERALD M. TIERNEY
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within 30 days from the date of this Order by filing a Notice of Appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esq., Associate Solicitor for Black Lung Benefits. His address is Room N-2117, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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[5] Dr. Rizkalla also found that pneumoconiosis hastened the miner's death. However, Dr. Rizkalla diagnosis of pneumoconiosis by the autopsy evidence was not accepted. *See* footnote 3, *supra*.